Substance Abuse Treatment Integration: Increasing Primary Care Capacity

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Speakers

Moderator:
Constance Burke, NYS Office of Alcoholism and Substance Abuse Services, Division of Outcome Management and System Information

Panelists:
Dr. Hillary Kunins, NYC Department of Health and Mental Hygiene
Dr. Sandeep Kapoor, Northwell Health
Dr. James Anderson, Leatherstocking PPS

A Continuum of Substance Use Services for Primary Care

Hillary Kunins, MD, MPH

Bureau of Alcohol and Drug Use Prevention, Care and Treatment

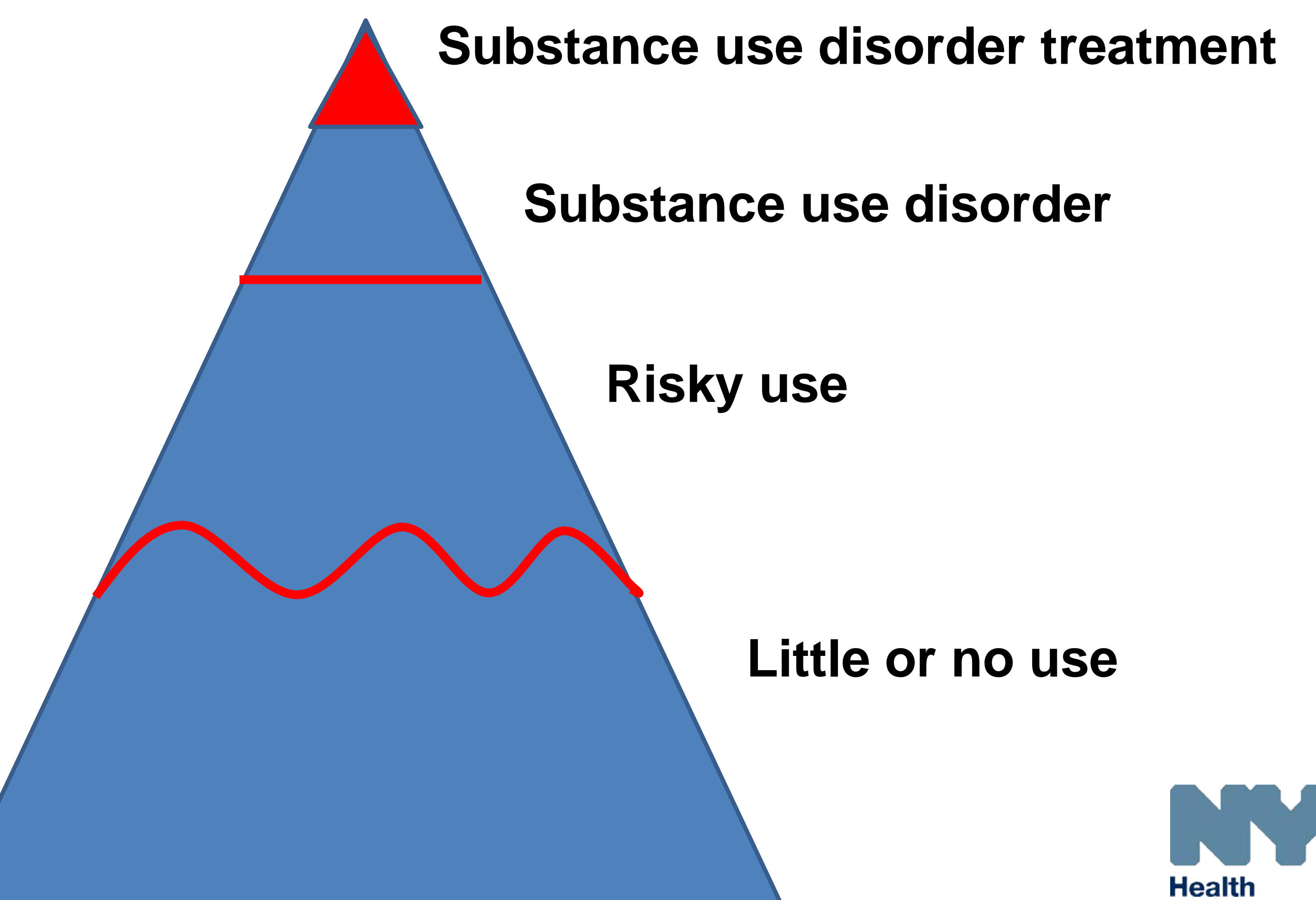
Department of Health and Mental Hygiene

September 21, 2016

Why are we here?

- Opioid overdose deaths are a public health crisis in New York City
  - These deaths are preventable
- Unhealthy substance use often goes unrecognized
  - A variety of services delivered in primary care can be integrated and are effective
- We need your help!

The pyramid of use



Outline

- Substance use epidemiology in New York City
- Benefits of integration
- Variety of services/strategies that can be integrated
  - Judicious prescribing
  - Screening, Brief Intervention, and Referral to Treatment
  - Pharmacotherapy for substance use disorder
  - Harm reduction practices: naloxone and sterile syringes
  - Relapse prevention support
- Questions and discussion

SUBSTANCE USE EPIDEMIOLOGY IN NEW YORK CITY

Alcohol attributed to the deaths of nearly 1,800 New Yorkers in 2013

Cause	Deaths
Alcoholic Liver Disease	383
Alcohol-related psychiatric disorders	178
Other Disorders	150
Homicide	156
Suicide	125
Motor-vehicle accidents	91
Any other accidents and poisonings	366
Liver Disease	141
High Blood Pressure	76
Cancer	36
Other Conditions	34
Heart Disease	22
Stroke	36

0 50 100 150 200 250 300 350 400 450

Top 3 deaths

*** rounding causes sum of specific causes to exceed total attributable deaths. In those cases, single deaths are eliminated from the non-direct causes with the highest frequencies to bring the sum in line with the actual total.*

Source: Zimmerman R, Li W, Begier E, Davis K, Gambatese M, Kelley D, Kennedy J, Lasner-Frater L, Madsen A, Maduro G, Sun Y. Summary of Vital Statistics , 2013:Mortality New York NY: New York City Department of Health and Mental Hygiene, Office of Vital Statistics, 2015. NOTE: Among NYC residents ages 20 years or older.

Alcohol consumption, New York City, 2014

Percent

60
50
40
30
20
10
0

54.3%
16.5%
28.9%

Current drinking
Binge drinking
Binge drinking among current drinkers

Current drinking: Consumed at least one alcohol drink in past 30 days

Binge drinking: Consumed 5 or more drinks on one occasion for men or 4 or more drinks on one occasion for women in the past 30 days

Source: New York City Community Health Survey, 2014

Most NYC adults have not discussed alcohol use with a health professional

- Only 24% of NYC adults report a doctor, nurse or other health professional had asked or talked to them about their alcohol use in the past year

- Screening for alcohol use is not a routine part of clinical care for adults in NYC

Source: New York City Department of Health and Mental Hygiene Community Health Survey, 2011

Unintentional drug poisoning deaths, NYC, 2000-2014*

Year	Number of unintentional opioid analgesic poisoning deaths	Age-adjusted rate per 100,000
2000	638	10.2
2001	792	12.2
2002	723	11.5
2003	769	12.2
2004	722	11.5
2005	796	12.5
2006	838	13.3
2007	695	10.9
2008	618	9.6
2009	593	9.1
2010	541	8.2
2011	630	9.4
2012	730	10.9
2013	788	11.6
2014	797	11.7

Left axis: Number (0–900). Right axis: Age-adjusted mortality rate per 100,000 (0–14).

■ Number of unintentional opioid analgesic poisoning deaths — Age-adjusted rate per 100,000

*Data for 2014 is preliminary and subject to change.

Source: New York City Office of the Chief Medical Examiner &
*New York City Department of Health and Mental Hygiene 2000-2014**

Unintentional heroin poisoning deaths increased 116% from 2010 to 2014*

Year	Number of unintentional heroin poisoning deaths	Age-adjusted rate per 100,000
2000	373	5.9
2001	416	6.4
2002	400	6.4
2003	438	6.9
2004	358	5.7
2005	379	5.9
2006	388	6.1
2007	301	4.7
2008	317	4.9
2009	288	4.4
2010	209	3.1
2011	284	4.2
2012	382	5.7
2013	424	6.2
2014	458	6.7

Left axis: Number (0–500). Right axis: Age-adjusted mortality rate per 100,000 (0.0–8.0).

*Data for 2014 are preliminary and subject to change.

*Source: New York City Office of the Chief Medical Examiner & New York City Department of Health and Mental Hygiene 2000-2014**

How did we get here?

- Opioid Analgesics
  - Increased prescribing
    - Opioid analgesic prescribing quadrupled from 1999 to 2010
    - Promotion of opioid analgesics for use in chronic non-cancer pain
    - Misperceptions related to efficacy
  - Risk for dependence and overdose underappreciated
    - By both patients and providers
    - Because it's a prescription, people think it's less risky (but just as dangerous as many illicit drugs)
- Heroin
  - Increased exposure to opioid analgesics
  - Decreased sense of risk associated with heroin

HOW CAN INTEGRATION OF SUBSTANCE USE SERVICES HELP?

Benefits of integration

- Improves access to treatment
- Improves patient outcomes (including treatment retention)
- Supports relapse prevention
- Allows to address coexisting health risks & illness
- Reduces stigma

Why treat substance use disorders in primary care?

- It works.
- Reduces substance use
- Improves overall health
  - Prevent death
  - Prevent and treat HIV, hepatitis C, other medical conditions
- Improves functioning
  - Employment, family and parenting
  - Decreases criminal activity

Why integrate substance use in primary care?

- Professional satisfaction. Really.
- Not everyone wants (or needs) to get treatment in specialized drug treatment settings.
- Primary care can make a difference in the opioid epidemic.

A word on stigma

- Significant stigma related to substance use and treatment for substance use disorder—pervasive in society
- Misconception of substance use disorder as a moral failing
- Consequences of stigma
- You will help by integrating substance use services into primary care practice

SERVICES AND STRATEGIES YOU CAN INTEGRATE

Services and strategies

1. Prescribe judiciously (opioids and benzos)
2. Screen and intervene
3. Treat or refer effectively.
   - Pharmacotherapy for opioid use disorders (buprenorphine)
   - Pharmacotherapy for alcohol use disorders
4. Prescribe naloxone for opioid overdose rescue
   - patients with opioid use disorder; patients on prescribed high-dose opioids
5. Provide relapse prevention/support
6. Offer sterile syringes

Judicious opioid prescribing

Clinical Advisors
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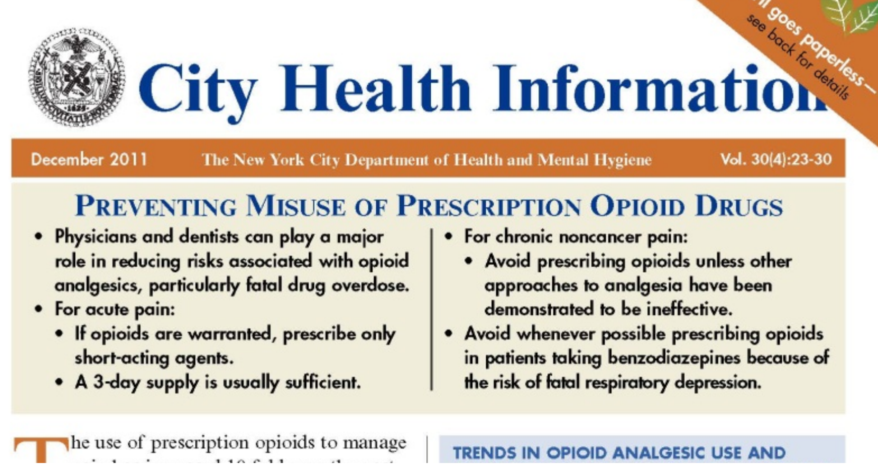
CHI goes paperless— see back for details

City Health Information

December 2011 The New York City Department of Health and Mental Hygiene Vol. 30(4):23-30

PREVENTING MISUSE OF PRESCRIPTION OPIOID DRUGS

- Physicians and dentists can play a major role in reducing risks associated with opioid analgesics, particularly fatal drug overdose.
- For acute pain:
  - If opioids are warranted, prescribe only short-acting agents.
  - A 3-day supply is usually sufficient.
- For chronic noncancer pain:
  - Avoid prescribing opioids unless other approaches to analgesia have been demonstrated to be ineffective.
- Avoid whenever possible prescribing opioids in patients taking benzodiazepines because of the risk of fatal respiratory depression.

The use of prescription opioids to manage

TRENDS IN OPIOID ANALGESIC USE AND

- Avoid prescribing opioids for chronic non-cancer, non-end-of-life pain
  - e.g., low back pain, arthritis, headache, fibromyalgia
- When opioids are warranted for acute pain, 3-day supply usually sufficient
- If dosing reaches 100 MED, reassess and reconsider other approaches to pain management
- Avoid whenever possible prescribing opioids in patients taking benzodiazepines

OpioidCalc

●○○○○ Sprint 3G 12:17 PM

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Total Daily MME = 180.0

MME ≥ 100 click for more info

Codeine

➕ Add Additional

Fentanyl transdermal (in mcg/hr)

50mcg per patch 120.0

(each patch used for 3 days)

➕ Add Additional

Hydrocodone

10mg (6 per day) 60.0

➕ Add Additional

Hydromorphone

➕ Add Additional

Methadone

Judicious benzodiazepine prescribing

- Increased risk of fatal overdose when benzodiazepines are taken with opioid analgesics, alcohol, or other CNS depressants
- If benzodiazepines are indicated, prescribe the lowest effective dose for the shortest duration—no more than 2-4 weeks
- Avoid co-prescribing benzodiazepines and opioid analgesics because of the risk of fatal respiratory depression

NYC™
Health

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- Reduces alcohol consumption and decreases health care utilization; ranked as one of the five most effective clinical preventive services
- Goal: Identify patients at-risk for unhealthy drinking
- SBIRT components
  - Screening using a validated tool
  - Brief intervention (if needed)
  - Referral to treatment (if needed)

1. Jonas DE, Garbutt JC, Amick HR, et al. Behavioral Counseling After Screening for Alcohol Misuse in Primary Care: A Systematic Review and Meta-Analysis for the U.S Preventive Services Task Force. *Ann Intern Med*. 2012 6; 157(9): 645-54.
2. McKnight-Eily LR, Liu Y, Brewer RD, et al. Vital Signs: Communication Between Health Professionals and Their Patients About Alcohol Use—44 States and the District of Columbia, 2011. *MMWR* 2014; 10;63(1):16-22.

Health Department SBIRT resources

January/February 2011 The New York City Department of Health and Mental Hygiene Vol. 30(1):1-8

Brief Intervention for Excessive Drinking

- Ask every patient about alcohol consumption using the 3-question AUDIT-C screening tool for adults and the CRAFFT tool for adolescents.
- Provide clear advice to moderate- and high-risk patients to reduce alcohol consumption.
- Provide regular follow-up to support efforts to achieve low-risk drinking levels.

Most adults in the United States (US) drink safely or not at all, but excessive drinking is common. In 2007 and 2008 combined, 23% of New Yorkers aged 21 years and older reported consuming 5 or more alcoholic drinks over a 2-hour period within the previous 30 days.[1]

Alcohol use is associated with high morbidity and

use in pregnancy can cause miscarriage, premature birth, and developmental impairments, including fetal alcohol syndrome.[15]

Up to 20% of patients in primary care practices may be engaged in excessive drinking.[16] Because patients are receptive to alcohol screening and counseling from their primary care physicians (PCPs),[17] and up to 40%

And…SBIRT E-learning module – coming soon!

Offer pharmacotherapy for substance use disorder

- Alcohol use disorder
  - Naltrexone and acamprosate are effective
- Opioid use disorder
  - Opioid agonists (buprenorphine or methadone) is the most effective form of treatment
    - Emerging evidence for long-acting injectable naltrexone
  - Buprenorphine can be offered in primary care

Treatment with opioid agonist medications – methadone and buprenorphine

- How these work: bind to opioid receptors in body
- Block effect of heroin or opioid analgesics
  - Prevent withdrawal and relieve craving
  - Block euphoric effects of other opioids
- Most effective treatments for addiction to heroin and opioid analgesics

Buprenorphine CHI

Volume 34 (2015) The New York City Department of Health and Mental Hygiene No. 1; 1-8

Buprenorphine—An Office-Based Treatment For Opioid Use Disorder

- Buprenorphine treatment is a life-saving tool for patients with opioid use disorder.
- Learn to recognize opioid use disorder and recommend effective treatment.
- Incorporate buprenorphine treatment into your practice.

New initiatives to increase access to buprenorphine in NYC

1. Buprenorphine training for physicians, nurse practitioners, physician assistants

2. Practice support to help integrate buprenorphine treatment at your practice

Offer naloxone for opioid overdose prevention

- Prescribe naloxone to your at-risk patients:
  - High-dose prescription (≥100 MMEs/day)
  - Chronic opioid therapy (≥3 months)
  - Opioid misuse/illicit use
  - Family member or friend of at-risk individual
- NYC DOHMH prescribing guidance and patient materials on our website
- Alternatively, refer patients to harm reduction programs or pharmacies

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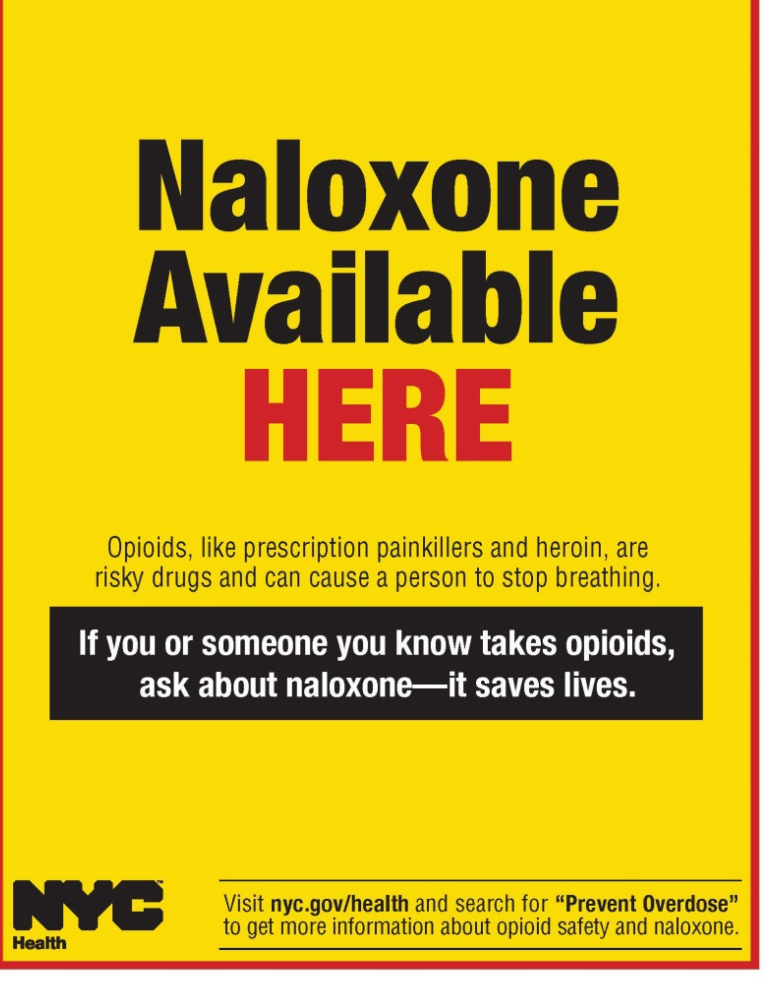
>700 NYC pharmacies now dispense naloxone under standing orders (many across NYS



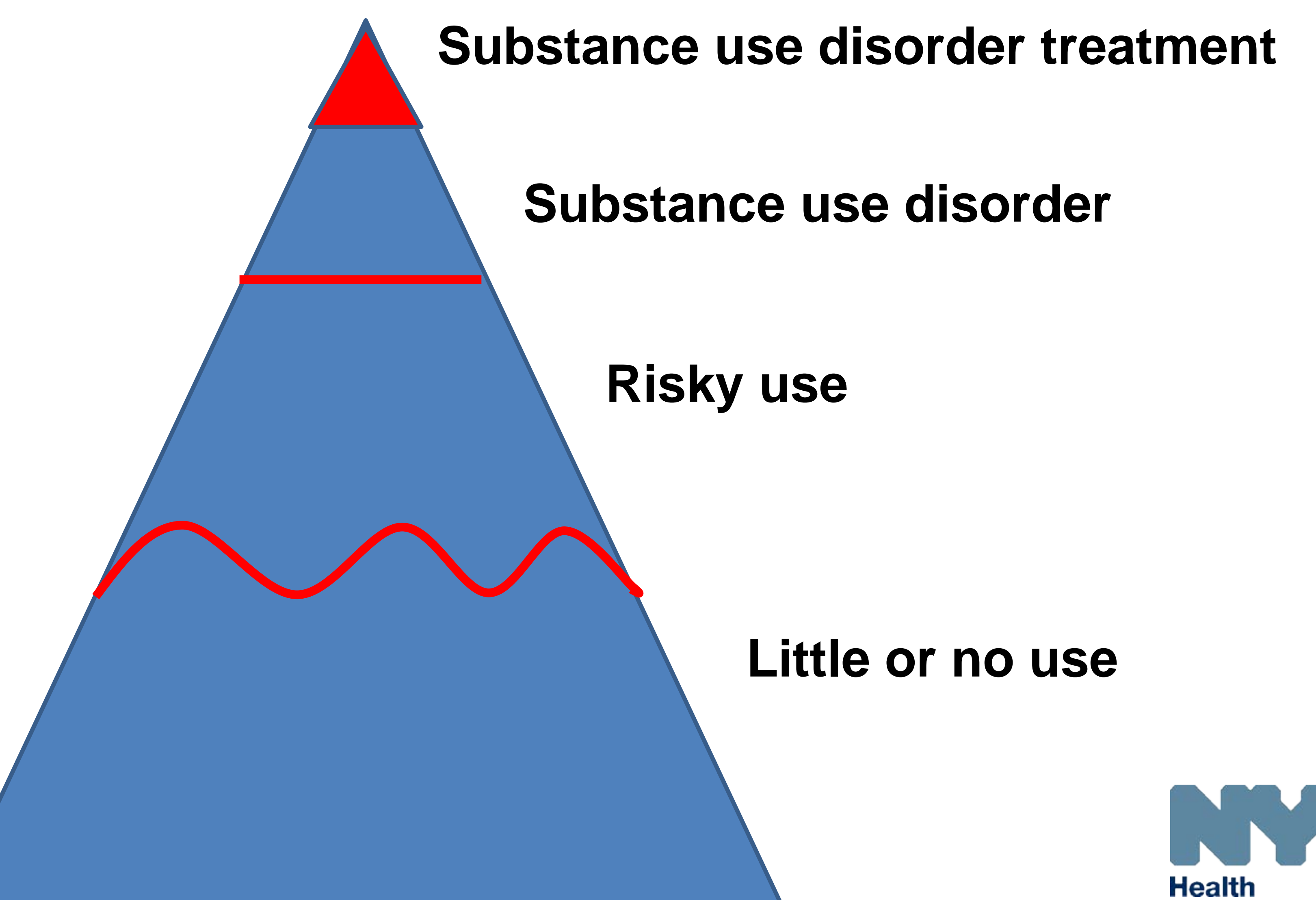
Provide sterile syringe access

- Prescribe sterile syringes
  - Register with Expanded Syringe Access Program (ESAP)
- Refer patients to ESAP pharmacies or harm reduction programs

Provide relapse prevention support

- Help your patients understand that substance use disorders are chronic conditions; slips or relapses common
- Several frameworks can help
  - PRIMECare Model
  - Recovery management checkups
- Link patients to peer-based support

The pyramid of use

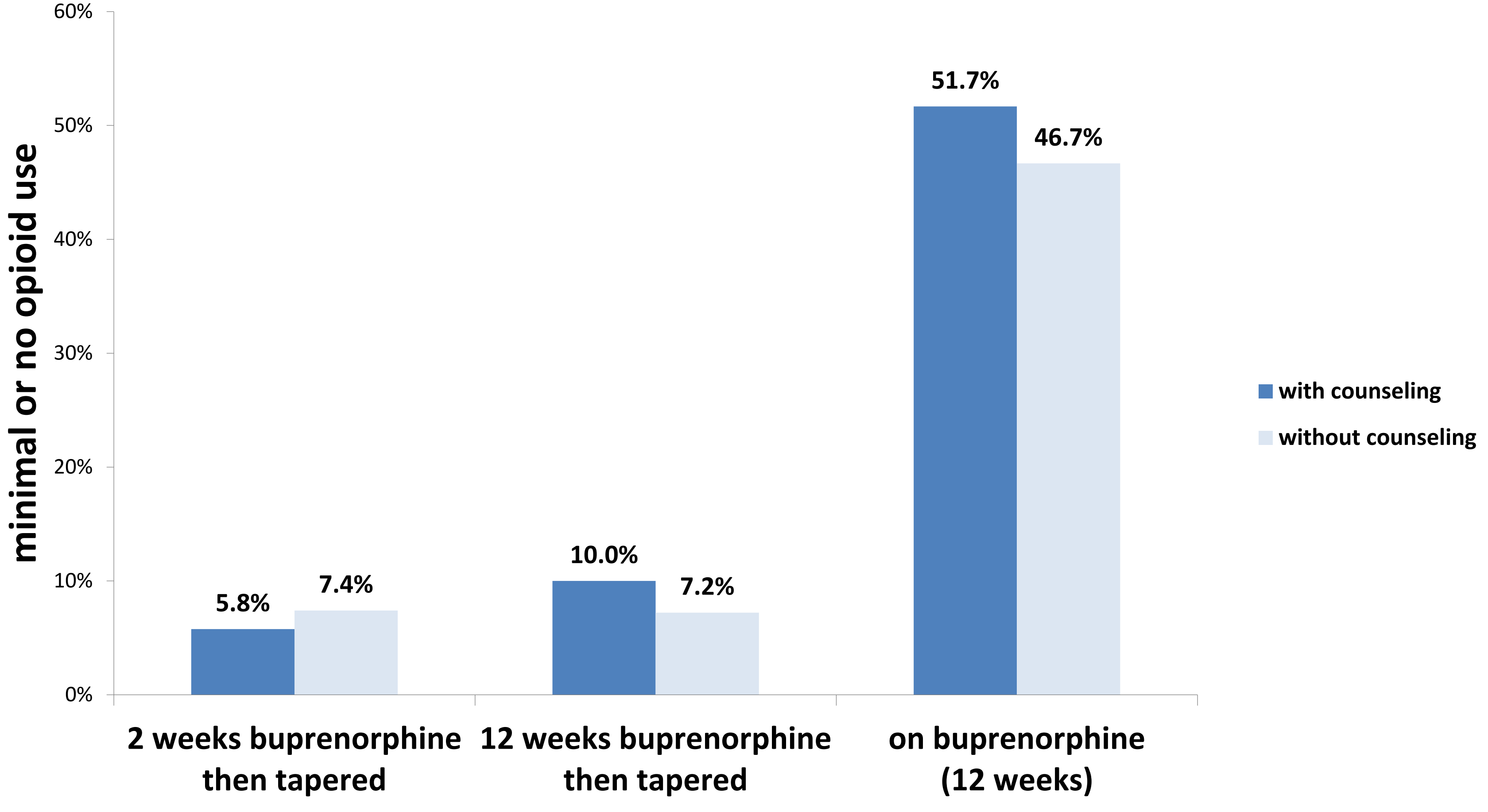


Concluding thoughts

- You can integrate a variety of effective substance use services into primary care
- Many services are simple and brief
- Small proportion of patients will need
- NYC DOHMH can help support you
- We need your partnership!
- Together we can address unhealthy substance use and overdose and improve the health of our community

Questions?

5 times more patients avoid relapse with buprenorphine maintenance than detox



From Weiss RD et al. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence. A 2-phase randomized controlled trial. *Arch Gen Psych* 2011;68: 1238–1246.

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3 phases of buprenorphine treatment

1. Induction:
   - Find optimal starting dose, without going through withdrawal; 2-3 days
   - Home inductions common, with close monitoring by physician during this period
2. Stabilization
   - Find minimum dose to prevent withdrawal and reduce/stop other opioid use
   - Dose ranges from 2-24mg per day
3. Maintenance
   - Continue to take prescribed dose at home
   - Regular medical appointments (variable interval)
   - Assess and offer/refer for counseling or other services

How long should a person take buprenorphine?

- Every person is different → depends on individual
- Better outcomes with longer treatment
- Diabetes treatment analogy

Federal policy and buprenorphine prescribing

- Licensed physicians (MD or DO) with DEA waiver; NEW: NPs, and PAs
- Criteria for waiver
  - Complete 8 hours of buprenorphine CME OR subspecialty in addiction
  - Capacity to refer to counseling
- Maximum 30 patients during first year; can increase to 100 after first year; NEW 275 patients in year 3 for some physicians

My (former) patient

- 54 year old Bronx grandmother
  - Former bookkeeper
  - Foster mother to an 8 year old autistic girl
  - 3 adult children; divorced
  - High blood pressure and diabetes

My (former) patient

- Heroin use began in her 20s
- Addiction treatment
  - Entered methadone in late 30s
  - >20 years methadone treatment
  - Tapered off methadone ~4 years ago
- Approximately 2 years ago
  - Knee injury, prescribed opioid analgesics
  - Escalated dose
- Wants to obtain care for addiction
  - Now daily heroin use

My (former) patient

- We offered her buprenorphine
- She initiated treatment with buprenorphine
  - Heroin use ceased
  - Met with me regularly
  - Remained in treatment
  - Maintained an active relationship with grandchildren and family

Summary

1. Addiction is a chronic disease that may need long term treatment

2. Treatment works

3. Treatment with medications works best

- Best evidence for methadone and buprenorphine; emerging evidence for injectable long-acting naltrexone

4. Treatment in primary care is possible and sometimes the only setting acceptable to the patient

- DOHMH has resources that can help support you get started

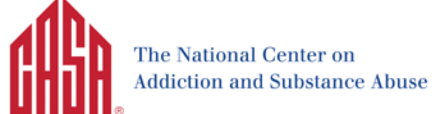
NYC Health

SBIRT Implementation

Informing Statewide Dissemination based on Lessons Learned

New York State DSRIP
Learning Symposium
September 21, 2016
130pm

Sandeep Kapoor, MD
Northwell Health
Hofstra Northwell School of Medicine



S
B
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R
T

@ Northwell Health

Northwell Health

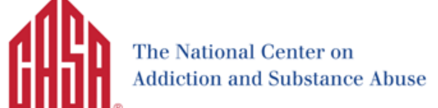
Center for Addiction Services and Psychotherapy Interventions Research (**CASPIR**)

Division of General Internal Medicine

Department of Emergency Medicine

Department of Psychiatry & Behavioral Health

The National Center on Addiction and Substance Abuse (CASA)



New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Substance Abuse and Mental Health Services Administration (SAMHSA)

SBIRT Leadership

Northwell SBIRT

Jon Morgenstern, PhD
Principal Investigator – Psychiatry

Joseph Conigliaro, MD, MPH
Principal Investigator – Internal Medicine

Nancy Kwon, MD, MPA
Principal Investigator – Emergency Medicine

Sandeep Kapoor, MD
Director, NSLIJ SBIRT

Northwell Department of Medicine

Thomas McGinn, MD, MPH
Chairman, Medicine

Jeanne Morley, MD
SBIRT MD Champion – Internal Medicine

Lauren McCullagh, MPH
Administrative Director - Research

Northwell Dept. of Emergency Medicine

John D'Angelo, MD
Chairman, Emergency Medicine

Mark Auerbach, MD, MBA
SBIRT MD Champion

Mae Ward, RN
Administrative Director – Research

Karen Kline
Senior Administrative Director II

Northwell Department of Psychiatry

John Kane, MD
Chairman, Psychiatry

Bruce Goldman, LCSW
The Zucker Hillside Hospital

Daniel Coletti, PhD
The Zucker Hillside Hospital

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

Connie Burke, MA
NYSBIRT Project Director

The National Center for Addiction and Substance Abuse (CASA)

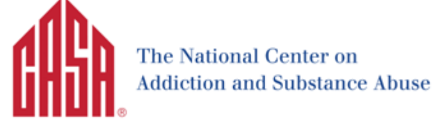
Charlie Neighbors, PhD
Director

Megan O'Grady, PhD
Associate Director

Northwell Sites for SBIRT Services

Montefiore
(Strategic Alliance)
Hackensack
(Strategic Alliance)
Lenox Hill
MEETH
CASAColumbia
(Strategic Alliance)
Lenox Hill
HealthPlex
(under construction)
Forest Hills
Zucker Hillside
Cohen Children's
North Shore University
The Feinstein
Long Island Jewish
Hofstra North Shore-LIJ School of Medicine
Franklin
Glen Cove
Syosset
Plainview
Nassau University
(Affiliate)
Huntington
Southside
South Oaks
Staten Island University (North)
Staten Island University (South)

Emergency Department
Internal Medicine Practice



To ***identify*** and effectively ***intervene*** with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.

Services Delivered

During SBIRT Health Coach Hours

Dec2013 - Aug2016

Completed PreScreens	PreScreen Positive	Brief Interventions	Referrals to Treatment
175,215	11%	6,264	1,281

1 IN 4

AMERICANS WHO FIRST SMOKED, DRANK OR USED OTHER DRUGS BEFORE AGE 18 HAS A SUBSTANCE PROBLEM

Compared to 1 in 25 Americans who first drank, smoked or used other drugs at age 21 or older

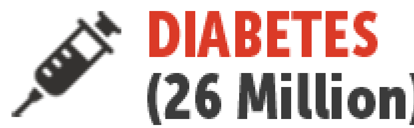
PEOPLE WHO NEED TREATMENT RECEIVE IT.

40 Million or >1 in 7

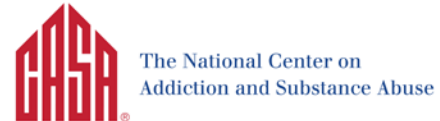
AGES 12 AND OLDER HAVE A SUBSTANCE PROBLEM...

...THIS IS MORE THAN THE NUMBER OF AMERICANS WITH:

(27 Million)



(26 Million)



The National Center on Addiction and Substance Abuse

CASAColumbia. (2012). *Addiction medicine: Closing the gap between science and practice*.

The Issue

Major source of referrals to treatment are **NOT** healthcare providers, though most people see a doctor at least one time per year

only 6.6%

Reference: SAMHSA (2011). 2010 National Survey on Drug Use and Health

Rethinking Substance Use Problems From a Public Health Perspective

Dependent Users

At risk and binge drinkers

Clinical Practice

The SBIRT Process

'Starting the conversation…'

SBIRT	Components
Pre-Screening **Audit-C/DAST-1/Tobacco**	Brief strategy to identify at-risk population using a valid, brief standardized questionnaire at the initial point of service **< 1 minute**
Full Screening **AUDIT/DAST-10**	Valid extended standardized questionnaire administered with patient if they qualify based on the prescreen scores **< 3 minutes**
Brief Intervention	One or more discussions with health care professional focused on reducing or stopping unhealthy substance use: 1. Assessment & feedback on substance use 2. Simple advice, goal setting, agree on plan **10-20 minutes**
Referral to Specialty Treatment	Based on extent of substance use/abuse, patients may require more than a brief intervention Every effort is made, in real-time, to provide a 'warm handoff' to community treatment providers and those within the NSLIJ Health System.

The Brief Negotiated Interview

A semi-structured interview process based on Motivational Interviewing that is a proven evidence-based practice and can be completed in 5–20 minutes

Steps in the BNI

1. Raise the Subject
2. Provide Feedback
3. Enhance Motivation
4. Negotiate and Advise

Special acknowledgement is made to Drs. Stephen Rollnick, Gail D'Onofrio, and Ed Bernstein for granting permission to orient participants to the "brief negotiated interview."

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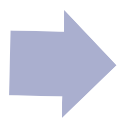
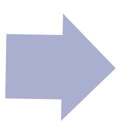
ED Workflow

Patient enters the Emergency Room



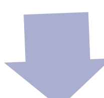
Patient is pre-screened by RNs after vital signs



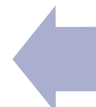
Responses from pre-screen are documented into EMR

*Positive screen will elicit an ICON to the Health Coach.

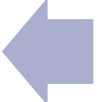
*Negative screens will be tracked



Health Coach will perform full screen and provide brief intervention, brief treatment or referral to treatment for positive full screens



Health Coach will present to treating MD/NP/RN as needed



Interaction is documented with the EMR

SBIRT Team-Based Model @ Northwell Health

Patient

- Nurses
- Medical Assistants
- SWs
- SUD Providers
- Health Coaches
- Physicians

Strategic Team-Based Approach

- **Provide Information and Structure**
- Elicit Feedback
- Tailor Service to Individual Site
- Provide Focused Training
- Pilot and PDSA
- 'Go LIVE'
- **Performance Monitoring, Training, continual PDSAs**

Elicit Feedback

Gauge Interest and Buy-In

- Health System Leadership
- Site Specific Leadership
- Clinical Frontline Leadership
- Clinical Frontline Staff

Tailor Service

Workflows

- Evaluate existing
- Introduction o f SBIRT
- Workarounds! (IT/Paperwork/Etc.)
- Clinical Frontline Staff Feedback Cycles

Northwell Health

Timeline

Northwell Health

NEW YORK STATE Screening, Brief Intervention and Referral to Treatment

A Program of the New York State Office of Alcoholism and Substance Abuse Services

CASA The National Center on Addiction and Substance Abuse

EHR Integration

PreScreen Questions and Scoring Algorithm

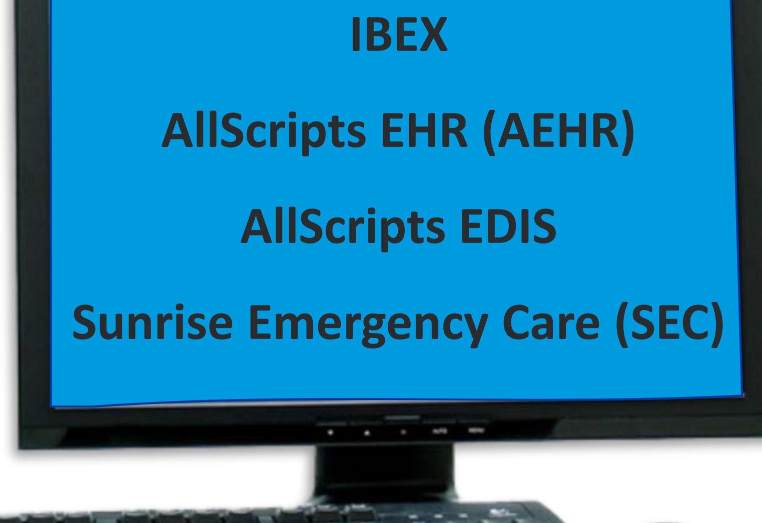
Automatic Tasking, Flagging, and Icons

Health Coach Documentation Note

Advancements

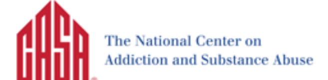
Automated Reports

'Two-Way' Handshake Data Transfer



Brief Internal Evaluation Results

	RN/MA	MD
Implementation disrupted workflow	10	7
Implementation increased patient wait time	6	12
Favorable to SBIRT implementation at my site	70	86



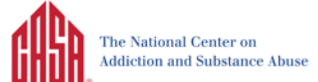
How Much Effort?

Team-Based Approach

?? %	?? %	?? %
Strategize	Organize/Implement	Maintain/Sustain

Take Away

- Strategic Approach – Sustainable?
- Truly a ***Team-Based*** approach for:
    - Implementation
    - Delivery of Care
    - Maintenance
- Closing loops of feedback, will go a long way!
- Just ***BIG*** enough, and just ***SMALL*** enough to use as a Pioneer Project to further integration



Thank You

For more information

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Office-Based Medication-Assisted Treatment for Opioid Addiction

Bassett Healthcare Network

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Licensed Psychologist
DSRIP Medical Director
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Increase in Prescription Rates

Figure 1 - Opioid Prescriptions Dispensed by US Retail Pharmacies IMS Health, Vector One: National, years 1991-1996, Data Extracted 2011. IMS Health, National Prescription Audit, years 1997-2013, Data Extracted 2014.

Increase in Overdoses

Opioid analgesics

Heroin

Deaths per 100,000 population

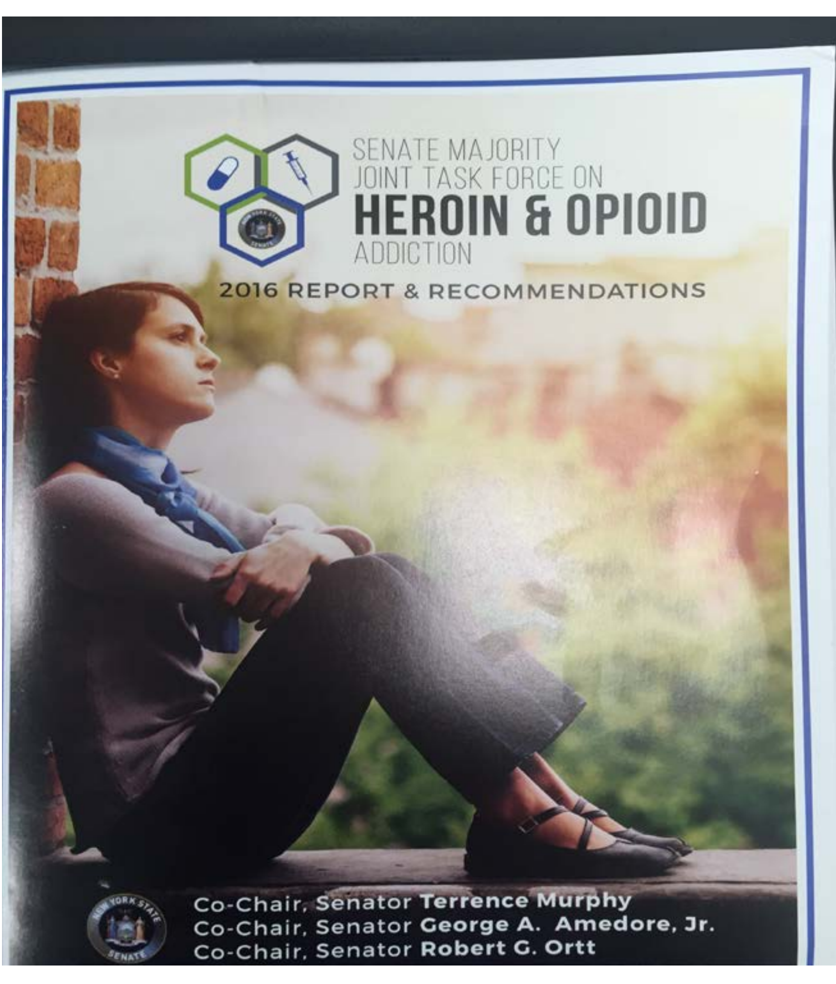
6
5
4
3
2
1
0

2000 2002 2004 2006 2008 2010 2012 2013

Year

Leatherstocking Collaborative Health Partners

Bassett Healthcare Network



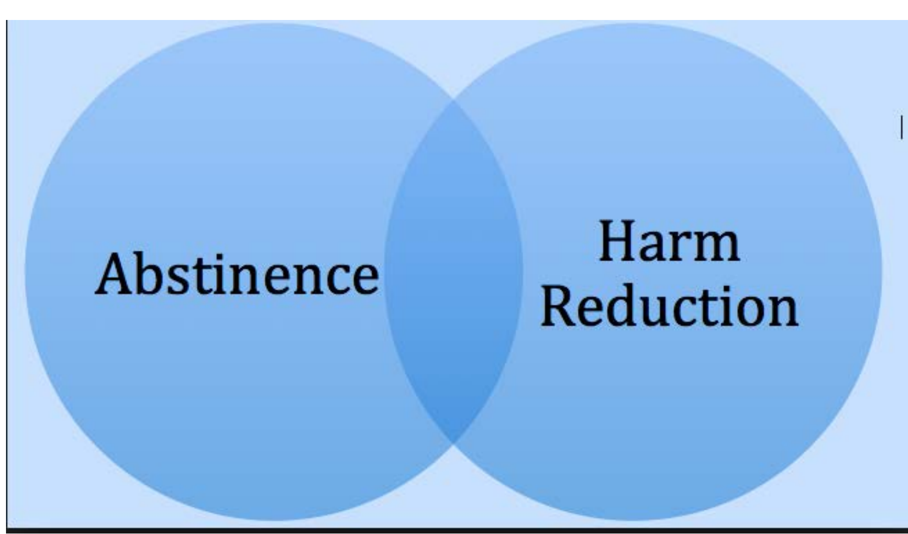
NYS Senate Task Force Statement on MAT

"Despite the success these drugs have in treatment, many providers have expressed concerns regarding the limited access to MAT due to a lack of programs…lack of education regarding the treatment"

(2016 report & recommendations, page 11)

Harm Reduction Philosophy

Concept of preventing or reducing negative consequences associated with certain behaviors (WHO)



Principles of Harm Reduction

- **Pragmatism**
  - *Are we going to eliminate drug use?*
- **Humanistic Values**
  - *Not approval, but not judgment*
- **Focus on damage**
  - *Not the behavior itself*
- **Balance of Costs & Benefits**
  - *Evaluation*
- **Focus on Immediate Goals**
  - *Prioritizing*

Office-Based Medication-Assisted Treatment for Opioid Addiction

- Requires a multi-disciplinary team
- Enables treatment of “whole person”
- Makes treatment more accessible
- Established efficacy for treatment of opioid-related disorders

Team-based Care for Opioid Dependence

Physicians, NPs, & PAs	•Assessing readiness •Dosing strategies •Drug screens •Hep C/HIV •Discontinuing Tx •Cross-coverage
Nurses & MAs	•Managing phone calls •Medication side-effects •Assessing mental health needs •Assessing Tx response •Pill counts & drug screens
Managers & Staff	•Responding to Pt concerns •Addressing disruptive behavior
Behavioral Health	•Counseling •Engaging families in Tx •Supporting prescribers
Whole Team	•Opioid dependence as a chronic disease •Harm reduction •Role of Family in Tx

Implementation Plan

- Identified 4 clinics interested in starting MAT
  - More may join by start date
- Contracted with MAT experts (U of MA Med School)
- Will have two, four-hour live trainings
  - CME credit
  - Progress towards “X-license” for physicians
- Weekly ECHO consultation for one year after on-site training
- Hired board-certified addiction medicine psychiatrist to join our team
- Internal & external behavioral health support
- DSRIP funds for care management & patient navigation

Q&A and Discussion